Patrick Petre
Hospital Director

Mission Statement
Arrowhead Regional Medical Center provides quality health care to the community.
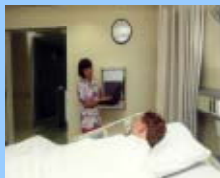
GOALS
INCREASE SELECTED MEDICAL CENTER VOLUMES

ENHANCE REIMBURSEMENT AND OTHER REVENUE STREAMS

DEVELOP/IMPLEMENT SOUND COST CONTAINMENT STRATEGIES

ENSURE A QUALITY FOCUS IN THE PROVISION OF PATIENT CARE SERVICES
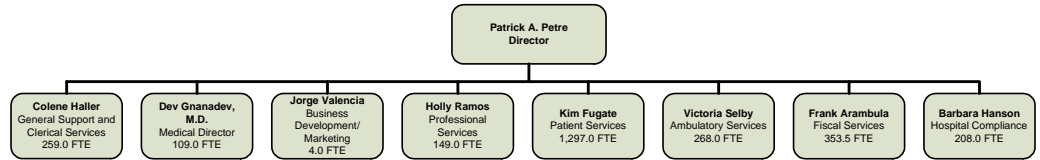
MAINTAIN/IMPROVE THE IT INFRASTRUCTURE

373 Inpatient Beds

Level II Trauma Center

ARROWHEAD REGIONAL MEDICAL CENTER

ORGANIZATIONAL CHART

Patrick A. Petre
Director

| Colene Haller General Support and Clerical Services 259.0 FTE | Dev Gnanadev, M.D. Medical Director 109.0 FTE | Jorge Valencia Business Development/ Marketing 4.0 FTE | Holly Ramos Professional Services 149.0 FTE | Kim Fugate Patient Services 1,297.0 FTE | Victoria Selby Ambulatory Services 268.0 FTE | Frank Arambula Fiscal Services 353.5 FTE | Barbara Hanson Hospital Compliance 208.0 FTE |

DESCRIPTION OF MAJOR SERVICES

Arrowhead Regional Medical Center (ARMC) is a state of the art, acute care facility embracing advanced technology in all patient care and support areas. The Medical Center offers the latest in patient care by providing a full range of inpatient and outpatient services, three off campus community health centers, Department of Behavioral Health's inpatient activities and numerous specialty services. Freeway access, shuttle service and locale as an Omnitrans bus hub makes ARMC convenient to county residents.

The campus houses five buildings which also serve to outline the definitive services/medical center functions: Behavioral Health, Hospital, Outpatient Care Center, Diagnostic & Treatment and the Central Plant.

The hospital and behavioral health facilities are comprised of 373 (90 behavioral health and 283 hospital) inpatient rooms, most of which are private. The Emergency Department is a Level II Trauma Center and consists of 15 observation rooms, 8 treatment rooms, 3 law enforcement holding rooms and 8 trauma rooms. In 2005, an Emergency Department remodel added a 9 bay Rapid Medical Emergent Treatment area to expedite treatment and improve throughput. The helicopter landing area can accommodate both standard medi-vac helicopters and military helicopters. The outpatient care center consists of 109 examination rooms and 8 procedure rooms.

The Medical Center remains one of the most technologically advanced health care institutions in the entire country. It is also seismically sound, capable of withstanding an 8.3 magnitude earthquake, and is designed to remain self sufficient and functional for a minimum of 72 hours.

Inpatient Care: Inpatient services provide curative, preventative, restorative and supportive care for general and specialty units within the General Acute Care Hospital, Behavioral Health Hospital and Home Health. Care is coordinated among multiple care providers responsible for patient care twenty-four hours a day.

The clinical staff serves as the primary interface with patients, families, and others throughout the hospital experience. Education is a primary focus. ARMC offers numerous Residency Programs for the training of physicians in Family Practice, Emergency Medicine, Surgery, Neurosurgery, Women's Health, Internal Medicine and Psychiatry.

Inpatient Service lines include:
- Inland Counties Regional Burn Center - provides total burn care to patients of all ages and serves San Bernardino, Riverside, Inyo and Mono Counties.
- Medical Intensive Care (MICU) and Surgical Intensive Care (SICU) – providing critical care for medical and surgical patients requiring continuous monitoring, assessment and treatment.
- Neonatal Intensive Care Unit (NICU)) – providing critical care for newborn premature/fragile infants.
- Maternal Child Services – providing labor, delivery, maternity and postpartum services.

- Newborn Nursery – providing full services for newborn infants.
- Operative Services provides surgical, invasive and peri-operative for all surgical procedures excluding cardiac. It is comprised of 15 OR suites, a three room Specialty Procedure Lab, Pre-Op Holding Area, Post Anesthesia Care Unit (PACU), Ambulatory Surgery Care (ASC), Pre-Op Clinic, Pain Clinic and three Obstetrical/Gynecological Operating Rooms.
- Pediatrics – providing assessment, observation and treatment of pediatric patients.
- Medical Surgical Services – Geriatrics, Orthopedics, telemetry patients requiring assessment, observation and treatment.
- Specialty Services – offered to patients who have special needs such as Dialysis, Cancer Care, Transplant (kidney) and wound care. Patient evaluation, follow-up, diagnostic planning, treatment and case management is also provided.
- Behavioral Health – Adult inpatient psychiatric treatment services which include evaluation, assessment and treatment by interdisciplinary teams of psychiatrists, nurses, psychiatric technicians, clinical therapists and occupational therapists. The program offers medication administration, individual & group therapy and family education.

Outpatient Services: Outpatient Care is an integral part of our multifaceted health care delivery system offering a wide range of emergency, primary, preventive, chronic, follow-up and specialty care services in an ambulatory care setting. Visits have exceeded 221,000 annually, excluding the Emergency Room volume.

Outpatient Service lines include:
- Emergency Medicine – ARMC is a very busy Level II Trauma Center offering acute, emergent and urgent treatment of patients. Visits are currently in excess of 106,000 annually.
- Primary care – consists of three outlying Family Health Centers (FHC's), offering comprehensive primary medical care for children and adults. These are community clinics that provide preventive, obstetrical and gynecological care, family planning services, well child visits, immunizations, health education and referral to specialty services:
  ➢ Fontana Family Health Center – Ivy Ave., Fontana
  ➢ McKee Family Health Center – Highland and Sterling, San Bernardino
  ➢ Westside Family Health Center – 8th Street, San Bernardino
- Specialty Clinics (ten) including:
  ➢ Infusion Therapy – provides therapeutic and supportive care to adult oncology patients and their families as well as chemotherapy, blood products, IV hydration and antibiotics.
  ➢ Internal Medicine – offering subspecialties of cardiology, lipid management, chest, diabetic, nephrology, endocrinology, gastroenterology, hematology, neurology and rheumatology.
  ➢ Surgery – sub-specialties of general surgery, wound care, burn care, urology, minor surgery and neurosurgery.
  ➢ ENT/ Audiology/Dental/Oral Surgery (Subspecialties of Surgery Clinic) – providing services for diagnosis and treatment.
  ➢ Ophthalmology (Subspecialty of Surgery Clinic) – pre-operative evaluation and post operative care Women's Health – offering comprehensive pregnancy services from preconception counseling to postpartum care including high risk maternal / child care.
  ➢ Orthopedic clinic – a wide range of services for diagnosis and treatment of diseases and abnormalities of the musculoskeletal system with emphasis on upper extremity, joint reconstruction, trauma, and spine.

2006-07 ACCOMPLISHMENTS

❖ *2006 NACo Achievement Award- Patient Visit Redesign - McKee FHC*
❖ *2007 NACo Achievement Award - the Breast Management Pathway*
❖ *Dr. Dev Gnanadev – CMA President Elect*
❖ *Dr. Joe Corless – AAFA Physician of the Year*
❖ *OneLegacy Recognition Award- Organ Donation*

❖ ***Successful Programs***
  ▪ *Breathmobile –"asthma clinic on wheels"*
  ▪ *"Walk-Run" fitness project*
  ▪ *Annual Breastfeeding Fair*
  ▪ *Annual Health & Safety Fair*
  ▪ *"Admin Grand Rounds" - Residency Programs*
  ▪ *Annual Foundation Golf Classic*
  ▪ *Victim's Advocacy Program*
  ▪ *Psychiatry Residency*

❖ *Successful Surveys*
  ▪ *Residency Programs*
  ▪ *Laboratory-CAP & CLIA*
  ▪ *ACS Oncology Svs*
  ▪ *ACS Trauma Svs*

❖ *Grant Awards*
  ▪ *AAFA-Breathmobile*
  ▪ *HRSA - Linear Accelerator*
  ▪ *Kaiser– Q. I.*
  ▪ *First Five - Dental*
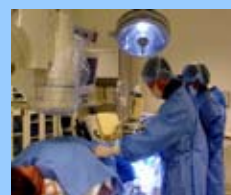
- ➢ Pediatric clinic – a variety of comprehensive services to children 0–18 years of age, well child visits, immunizations, high risk follow-up, sick child walk-in visits as well as pediatric specialty services of cystic fibrosis, neurology, endocrinology, asthma, diabetes, genetics, allergy, cardiology and hematology.
- ➢ Family Elder & Geriatric Care – serving elderly and frail elderly adults, their support systems, caregivers and families, offer consultative services for seniors, geriatric evaluation and management.
- ➢ Rehabilitation Clinic – conducts evaluations for State Disability, Rehabilitation/Treatment of amputees, spinal cord injuries, and strokes. Referrals are to Physical Therapy, Speech, Occupational Therapy and Prosthetics.

Ancillary/Support & Specialized Services: Complex healthcare systems are comprised of numerous ancillary and support departments that offer specialized diagnostic, treatment, rehabilitation and continuum of care services to both the inpatient and outpatient programs of the Medical Center, Those services include:

- **Medical Imaging Department (Radiology) –** utilizes a digitized imaging and archiving system which replaces x-ray film. Radiologists can remotely access and read images for expedited diagnostic interpretation. The Medical Imaging Department also performs Bone Densitometry, Mammography, CT scanning, MRI, Ultrasound, Nuclear Medicine, and Radiation Oncology.
- **Neurodiagnostics –** offers both inpatient and outpatient diagnostic studies. Tests performed include electroencephalograms (EEG), Continuous EEG, Electromyogram (EMG), Nerve Conduction studies and transcranial Dopplers.
- **Clinical Laborato**ry – responsible for inpatient and outpatient diagnostic services which include chemistry, hematology, coagulation, urinalysis, bacteriology, cytology, virology, mycology, serology, TB, blood transfusions, autopsy and surgical pathology. Approximately 1.6 million tests are performed annually in this 24 hour service.
- **Pharmacy –** provides comprehensive inpatient and outpatient pharmaceutical services. The outpatient Pharmacy operates an automated prescription filling system called Optifill II. The patient submits the prescription and it is entered into the computer and reviewed by a pharmacist. Once accepted, a label is printed; the computer initiates filling the bottle and caps the prescription. Quality assurance is completed prior to presenting to the patient.
- **Rehabilitation Services** – includes Physical Therapy, Occupational Therapy and Speech Therapy. The department evaluates and treats patients with neuromuscular, musculoskeletal, sensorimotor, cardiovascular, and pulmonary disorders, and language dysfunction. The goal is to restore the patient's functional activities of daily living to the highest possible level.
- **Respiratory Care** – offers a thorough practice of routine, prophylactic and intensive respiratory care modalities including gas and aerosol therapy, conventional mechanical ventilation, high frequency oscillatory ventilation, airway management, CPR, blood gas acquisition and analysis, non invasive monitoring and placement of percutaneous tracheotomies.
- **Home Health** – includes rehabilitative care, IV therapy and wound care extended to patient's home to complete the continuum of care.
- **Health Information Library** – offers a catalog of CD ROM, journals and computers with internet access for health care research and up to date information.
- **Wound Care and Hyperbaric Medicine** – directed specifically toward the healing of chronic wounds. Services include diagnostic testing/sharp debridement, casting and strapping for compression therapy, and patient education. Hyperbaric Oxygen Therapy (HBO) is offered to patients with specific types of difficult to treat wounds that are known to respond to HBO per Undersea and Hyperbaric Medical Society (UHMS) guidelines.

2007-08 SUMMARY OF BUDGET UNITS

	Operating Exp/ Appropriation	Revenue	Fund Balance	Revenue Over/ (Under) Exp	Staffing
Enterprise Fund					
Arrowhead Regional Medical Center	364,151,503	361,628,449		(2,523,054)	2,656.0
Total Enterprise Fund	364,151,503	361,628,449		(2,523,054)	2,656.0
Special Revenue Funds					
Tobacco Tax	2,258,056	1,717,828	540,228		-
Archstone Foundation Grant	44,509	10,802	33,707		-
Total Special Revenue Funds	2,302,565	1,728,630	573,935		-
Total - All Funds	366,454,068	363,357,079	573,935	(2,523,054)	2,656.0

GOALS, OBJECTIVES, AND PERFORMANCE MEASURES

GOAL 1: INCREASE SELECTED MEDICAL CENTER VOLUMES

Objective A: Increase Outpatient Clinic Visits through the continued implementation of outpatient visit redesign program in primary and specialty clinics.

Objective B: Reinitiate and grow Tattoo Removal Clinic business

Objective C: Continue to maintain upward trend in OB Deliveries

Objective D: Continue to grow Transplant Program

Objective E: Revitalize and grow Outpatient Plastic Surgery business

Objective F: Develop Inpatient Open Heart Program

Objective G: BURN Center: Pursue managed care contracts to increase marketability of Inpatient Burn services.

MEASUREMENT	2005-06 Actual	2006-07 Actual	2007-08 Target	2007-08 Estimate	2008-09 Target
1A. Percentage change of outpatient visits (number of visits).	N/A	(7.9%) (221,168)	4%	6.9% (236,464)	2%
1B. Reinitiate/Grow Outpatient Tattoo Removals (number of patients).	N/A	81	500	1200	1500
1C. Percentage increase in number of deliveries (3,780 in 2005-06).	N/A	5%	3%	5%	5%
1D. Grow Transplant Program (number of transplants).	N/A	7	16	10	12
1E. Resurgence of Outpatient Plastic Surgery (number of Plastic surgeries).	N/A	N/A	100	100	150
1F. Open Heart Surgeries – New Service.	N/A	N/A	N/A	N/A	50
1G. Increase average daily census for 14 Bed Burn Unit.	N/A	N/A	6.5	7.0	8.0

Status
1A. Outpatient visits at the Family Health Centers (FHC) and Specialty Clinics are on target for the first quarter 2007-08. A full time contracted physician was hired during this first quarter at Westside FHC. In an attempt to increase the clinic visits, the Medical Director for Ambulatory Services has assigned one of the attending physicians from the inpatient to outpatient services effective October 1, 2007. In an effort to stabilize the provision of services and increase clinic visits, Allied Health Care Professionals (PA/NP's) may offer a viable supplement to the provider staff. With medical provider stabilization, Patient visit redesign will be reviewed for feasibility of implementation to further enhance both throughput and capacity. The target of a 4% increase in outpatient visits was not achieved in 2006-07 due to difficulty in recruitment and retention of available providers in one of the three Family Health Centers.

In 2006-07, implementation of the Patient Visit Redesign Program began in the Family Health Centers and Specialty Clinics. Patient Visit Redesign is now complete at McKee and Fontana FHC's, Women's Health and Pediatric Clinic.   Cycle times (the time from registration to the time of discharge from the clinic) have decreased in all redesign clinics, decreasing patient wait times and increasing throughput. McKee FHC had a cycle time decrease from 86 minutes to 33 minutes and was awarded the 2006 NACo Achievement Award.   Internal Medicine is the next outpatient clinic slated for Patient visit redesign.

The Pediatric Clinic's cycle time improved from 120 minutes to 45 minutes. With the continuation of patient visit redesign in the Pediatric Clinic, a volume increase of 80-100 visits per month is estimated. To promote the Pediatric Program, a patient education and awareness program has been implemented, available in both Spanish and English, it outlines for parents the methods of accessing services. An IEHP (Inland Empire Health Plan) hotline was developed to assist our parent patients with provider enrollment (preventing auto assignment if selection is not made within 30 days) and offers answers to any questions they may have.   Finally, the Pediatric

Service will explore the possibility of providing Pediatric Services at the Holt Clinic in Ontario, expanding service throughout the community.

1B.   The Tattoo removal clinic was re-initiated in May 2007 to assist Correctional inmates and county residents who chose to have tattoos removed in an effort to facilitate re-entry into society and the job market following incarceration, gang participation, or disillusionment with visible body markings.   Laser removal is utilized in several sessions to eliminate the skin markings.   It is done in the outpatient setting as part of the surgery clinic. Within the first six weeks of opening, the clinic had seen 81 patients and in the first quarter of 2007-08, the number of visits has increased to 520.   Continued upward trend is anticipated.

1C.   In 2005-06, the number of infant deliveries at ARMC was 3,780.   As part of reaching the goal of increasing admissions in acute care services, ARMC's objective was to continue that upward trend.   In 2006-07, the number of deliveries increased to 3972 or 5%, which surpassed the target of a 1% increase, and in the first quarter of 2007-08, September proved to be a record month of 436 infant deliveries with a total for the quarter of 1165.   The increasing service requirements of infant deliveries challenge available bed capacity on a daily basis.   It is anticipated that the sixth floor remodel project slated for completion in the third quarter of 2009 will allow the growing post partum population to expand into the 3-South medical surgical area of the Nursing tower.

1D.   The transplant program is directly supported by the provision of Renal Dialysis.   In 2006-07, ARMC exceeded the target of 4 transplants, however for 2007-08 the target of 16 transplants will not be achieved.   The growth of the program is dependant on the hospital's ability to support its volume and with the sixth floor expansion and the building of the Medical Office Building (MOB), it is the intent of the Medical Center to expand outpatient dialysis to 24 stations thus meeting the requirements of a much needed patient care service and enhancing the ability to grow the transplant program.   Brochures are being completed and will be marketed directly to dialysis centers to educate the public and advertise the transplant services.

1E.   A resurgence of outpatient Plastic Surgery is anticipated with the return of two ARMC plastic surgeons.   The request to return to the Medical Center is motivated by the ability to deliver outpatient surgery in a familiar, state-of-the-art facility offering advanced technology and a safe environment for patient care.   It has been the Medical Center's goal to increase the number of outpatient surgeries.   The 2005-06 base was 4,764 and in 2006-07, the actual number of outpatient surgeries was essentially flat at 4,746.   For the first quarter of 2007-08 the outpatient surgery numbers are 656.   The focus in elevating outpatient surgeries will be on increasing the plastic surgery business. The re-addition of plastic surgery will enhance the overall outpatient surgery volume by an estimated 100 cases in 2007-08 and 150 cases in 2008-09.   In an effort to increase the overall outpatient surgery volume and accommodate the additional service, operating room access, the hours of service for outpatient surgeries have been expanded.   Additionally, unused operating room suites have been activated.

1F.   ARMC's plan to develop a Cardiac Surgery Program will enhance care for county residents and allow ARMC to move toward a Level 1 Trauma Center designation.   Currently, ARMC transports patients to other area hospitals when they require open-heart surgery and the Medical Center covers the cost for those without insurance.   That cost exceeds $2 million annually.   A full scope cardiac surgery program will decrease contractual costs for cardiac procedures and surgeries and complement services at ARMC for attaining a Level I Trauma Center designation. Program implementation is targeted for the first quarter of 2008-09.   An agreement has been entered into with a cardiac anesthesia group and the next steps will be to purchase the necessary equipment and contract with a cardiac surgery group.   Proposals for Cardiac Surgery are currently being reviewed.   In August of 2006, ARMC received Level II trauma-center verification from the Committee on Trauma of the American College of Surgeons (ACS), demonstrating that it has achieved the highest standards of quality care for injured patients.   ARMC's Trauma Center is the only trauma center in San Bernardino and Riverside Counties currently verified by the ACS. The goal is to attain Level I designation by 2009, at which time ARMC will be surveyed again.

1G.   ARMC's 14 bed Burn Unit currently runs at 35.7% capacity.   There is current migration of burn patients to other Southern California burn units due to contracting issues.   ARMC will assertively pursue a change in contracting strategy from percent of charges to per diems with high cost carve outs, demonstrating a willingness to share the risk of managing these patients.   ARMC has had some success with individual cases.   We are currently in discussions with Kaiser to convert our existing contract to per diems with high cost carve outs.   Other payors are opportunities as well, as seen by the individual cases that have presented to ARMC.   The nationally acclaimed Inland Counties Regional Burn Center is the only major burn center serving the four counties of Inyo, Mono,

Riverside, and San Bernardino. At the Burn Center, care is individualized to address each patient's requirements. Specialized nurses work with both general surgeons and plastic surgeons when caring for burn victims. Other members of the burn team include occupational and physical therapists, respiratory therapists, dieticians, a social worker and a psychiatrist.

The market economic nature of specialized healthcare services necessitates the appropriate pricing of Burn Unit services in order to build a strong program. Payors and patients have many options for these types of services. The Shared Risk format of this new strategy will improve our competitive nature of building incremental business with payors whom, up until now, have been reluctant to contract with ARMC.

2007-08 Performance Measures – removed from the 2008-09 Business Plan:

1B. The percentage of patients leaving the Emergency Department without being seen (LWBS) in 2007-08 decreased to 4837 (56%), while Emergency Room (ER) visits continued to rise, reaching greater than 106,000. The percentage of LWBS to total emergency department (ED) visits is a single digit number at 4.5%. That downward trend continues in the first quarter of 2007-08 and is projected to decrease an additional 15% as ER visits rise even further. An overall percentage of LWBS to total ED visits is targeted at 3.5% or less. ARMC will continue to monitor this performance measure internally, but it will be removed from the 2008-09 Business Plan.

1E. The targeted percentage increase in outpatient rehabilitation volume due to Workers' Compensation has not come to fruition. In 2006-07, a plan was developed and implemented to capture an increased portion of the workers' compensation referral base. This was a collaborative effort between Human Resources and ARMC through the Center for Employee Health & Wellness. ARMC held several events outlined in the marketing plan; however, the Medical Center has experienced some difficulty in joining the necessary Medical Provider Network. That application process is currently under review and will go forward for Board approval prior to 2007 year end. This project will continue, but will be removed from the 2008-09 Business Plan.

Note: Goals 1 and 2 in the 2007-08 Business Plan have been combined under Goal #1 for 2008-09 as "Increasing Selected Medical Center Volumes"

GOAL 2:   ENHANCE REIMBURSEMENT AND OTHER REVENUE STREAMS

Objective A: Continue to improve the financial screening and eligibility processes for government aid and new programs in the Emergency Department.

Objective B: Implement the Electronic Medical Record system with a targeted completion date of November 2008.

Objective C: Reorganize ARMC's Business Office to improve the revenue cycle components.

Objective D: Centralize and standardize the patient intake process at all points of entry for timely accurate information / data collection.

Objective E: Aggressively pursue claim denials related to charge capture, coding and medical billing compliance.

MEASUREMENT	2005-06 Actual	2006-07 Actual	2007-08 Target	2007-08 Estimate	2008-09 Target
2A. Percentage increase of Medi-Cal Eligibility patients identified from screening for conversion from self-pay (number of patients).	N/A	6% (16,546)	5.5%	2% (16,878)	2%
2B. Electronic Medical Record – Administrative portion -development and completion.	N/A	N/A	N/A	50%	100%
2C. Actual cash collections as a percent of projected net patient revenues.	N/A	N/A	100%	105%	105%
2D. Decrease in error rate (error rate estimated at 60% for 2006-07).	N/A	N/A	30%	>10%	>10%
2E. Decrease of denial rate related to charge capture, coding and medical billing compliance. (As of 2007/08, denial rate is at 68%.)	N/A	N/A	34%	34%	6.2%

Status
2A. In 2007-08, ARMC set out with the overall goal of improving all aspects of the revenue cycle. The component departments included Registration, Eligibility, Health Information Management (HIM), Case Management, Charge Description Master, Information Management and Business Office operations. ARMC is making sound,

ADMINISTRATIVE/EXECUTIVE

permanent progress with the coordinated efforts of each of these areas. ARMC has a higher percentage of revenue collected from Medi-Cal recipients versus self-pay patients. Therefore it is critical that every eligible Medic-Cal recipient be identified and billed as such. In 2005-06, ARMC identified 15,610 Medi-Cal recipients, and in 2006-07 this screening process identified an additional 6% of eligible patients or a total of 16,546. Although it was projected that this number would increase by 10% in 2006-07, ARMC was unable to reach its target. However, in both 2007-08 and 2008-09 this number is expected to increase by 2%.

2B.   Understanding that the management of clinical information is crucial to responding to Medicare, Medi-cal, Managed Care and Commercial payor requirements, ARMC has endeavored to finish development of a complete electronic record. This will allow ARMC clinicians and revenue cycle professionals full access to medical records necessary to facilitate a more timely payment of the patient bill without the hindrance related to only having a sole paper record. No longer will future charts be unavailable to multiple clinicians as needed. Clinical documentation that facilitates timely billing would also be readily available. The record will be a combination of electronically transmitted and scanned information to provide the availability of a complete patient document. In 2007-08 it is anticipated that 50% of the development of the electronic medical record system will be completed with 100% completion reached in November 2008. However, the clinical aspects of electronic patient documentation will continue in separate specific computerized modules to attain the goal of electronic transmission of a total patient record by the recommended timeline of 2010.

2C.   ARMC will establish a single department with global authority for obtaining the correct upfront information in a timely and complete manner, throughout the entire facility. An assessment of all current registration and eligibility processes is underway, and a priority list for conversion of frontline areas to a more centralized control has been developed. Staffing development and procedures are being developed for centralized control of Infusion Therapy and Labor & Delivery Non Stress Test clinic, which should be realized in the first quarter of 2008. The Labor & Delivery transition will also include the new function of Pre-Admission for our Labor & Delivery patients, which will not only facilitate patient access, but allow a thorough assessment of insurance eligibility and facilitate patient application to appropriate programs to assist customers in covering the financial expense of delivery.

2D.   Standards will be set and maintained for all employees performing registration and admission functions. During the last year, the "Dirty Registration List" has been developed and implemented. This list evaluates all registrations by registrar and identifies data entry errors on twenty-five different error criteria. The report is printed and corrected daily. The list has not only facilitated the education and accountability process for the frontline staff, but it is anticipated that it will positively impact the goal of establishing "clean accounts" to the fiscal department for billing purposes. According to the National Association of Healthcare Access Managers (NaHAM) the national standard for errors in registration is less than 5%. ARMC's long-term goal is to exceed the national standard and maintain an error rate of less than 2%. In 2006-07 it was estimated that ARMC's error rate was 60% and it is projected that it will decrease by half to 30% in 2007-08. The estimate for 2007-08 is to continue to decrease the error rate reaching the goal of an overall error rate of <10%.

2E.   Training programs will be established to facilitate meeting/exceeding set standards. Two full scope clerical training programs have been conducted in the last fiscal year. The training objectives are professional patient interview techniques, accurate and timely data entry, and proficient insurance eligibility assessment & special program application. In 2007-08 it is projected that ARMC will reduce its denial rate by half to a rate of 34% and in 2008-09 it is anticipated that the denial rate of 6.2% will be achieved.

Business office operations have been completely restructured in 2007-08 with new proactive leadership, improved access to appropriate resources, ongoing training, and implementation of operational procedures necessary to maximize revenue cycle results. Partial year benefits will affect 2007-08 with full year impact in 2008-09. With improved upfront information accuracy and timely billing, ARMC will greatly improve revenue cycle results thus maximizing cash due ARMC for patient billings.

Goal #3, 2007-08 Business Plan - Objective C, Performance Measure 3C, 2007-08 Business Plan – removed from 2008-09 Business Plan. The Direct Observation Unit was opened in February 2007 in an effort to decongest the Emergency Department and provide a holding area for patients needing care less than 24 hours. Separate billing was initiated for this unit as an outpatient service. However, due to staffing, patient flow and physician access issues, the unit was closed in August 2007. This performance measure has been removed from the 2008-09 Business Plan.

Goal # 3, 2007-08 Business Plan - Objective B: Initiating point of service collection for labor & Delivery and the Emergency Departments – will be captured in the broader scope of Objectives A through E under Goal #2. As a result of logistical and process issues in both departments, this plan has not yet been implemented. The current and ongoing re-design of the ED patient flow process will facilitate the establishment of a "departure desk/room" which will then allow ARMC to perform point of service cash collections in a safe and secure environment that meets county cash control expectations and is also in compliance with the Emergency Medical Treatment & Active Labor Act (EMTALA) rules and regulations.

| GOAL 3: DEVELOP/IMPLEMENT SOUND COST CONTAINMENT STRATEGIES |

Objective A: Continue to contain nursing labor costs through nursing skill mix and recruitment & retention efforts.

Objective B: Integration of ARMC and Public Health Laboratory services to decrease duplication of services and decrease costs by March 2009.

Objective C: Contain Pharmaceutical Costs below 2005-06 Budget in a market of increasing drug prices.

Objective D: Decrease overtime utilization by $ 300,000 below 2007-08 actuals.

Objective E: Supply Expense Containment.

MEASUREMENT	2005-06 Actual	2006-07 Actual	2007-08 Target	2007-08 Estimate	2008-09 Target
3A. Change ratio of registered nurses to Licensed Vocational Nurses (Achieve ration of 70%:30% RNs to LVNs in all Non Intensive Care Areas)	N/A	85/15%	85/15%	85/15%	82/18%
3A. Percentage decrease in Utilization Of Third Party Staffing Assistance - Nursing Registry. (millions spent)	N/A	53% ($1.6)	14%	16% ($1.3)	12.7%
3B. Demonstrate cost savings In laboratory supplies and labor	N/A	4,720	7,080	10,000	50,000
3C. Percentage change in pharmaceutical costs (millions spent)	N/A	(5%) ($22.1)	3%	1.5% ($22.5)	6.7%
3D. Percentage decrease in Overtime Utilization In Non Patient Care Departments And Patient Care Departments Demonstrating No Growth In Volume ($4.89 million spent in OT 2006-07)	N/A	N/A	10%	10% ($4.4)	6.8%
3E. Percentage decrease in total supplies expense ($64 million spent in 2006-07) :	N/A	N/A	1%	1%	3%

Status

3A. As part of an ongoing effort to contain costs where possible during the ongoing nursing shortage, ARMC continues to infuse Licensed Vocational Nurses (LVNs) in all pertinent non-intensive care areas of patient services. As part of the process, the nurse to patient skill mix ratio was restructured and this process was initiated in early 2007. As a result of the restructuring, LVNs were incorporated into the nurse to patient skill mix ratio for the non-specialty medical/surgical areas and the registered nurses (RNs) were cross-trained for the specialty areas such as Neonatal Intensive Care Unit (NICU) and Labor and Delivery. To date, 45 of the 72 LVN positions have been filled. LVNs have been hired to work in all non-specialty service areas, which include medical/surgical, post partum, labor and delivery, pediatrics, dialysis, wound care and the emergency department. To date, except for turnover, all non-specialty service areas have incorporated a minimum of one LVN per shift in staffing ARMC is currently at an 85%/15% RN to LVN ratio for 2006-07. ARMC will not pursue additional changes in skill mix and the RN to LVN ratios for 2006-07. Labor negotiations and retention issues throughout this fiscal year require a re-stabilization of the workforce in all specialty areas. In 2008-09 the medical center will continue its efforts toward the goal of 82% RN's and 18%LVN's.

Another opportunity for cost containment is the reduction in the usage of third party nurse staffing assistance or the Nurse Registry. This effort has been successful to date and was accomplished by enhanced nursing recruitment strategies and better control of unscheduled absences, which negatively affected the nursing staff. Registry usage during the first nine months of 2007 shows a 46% decrease in usage as compared to the same period in 2006. Registry usage was 13,085 hours (8.41FTEs) during the nine months in 2007, compared to 25,275 hours (16.24 FTEs) for the same period in 2006. Registry costs during the same period in 2007 were $869,091 as compared to $1,783,408 in 2006 for a total savings of $914,317. Reduction of registry usage during the third quarter of calendar year 2007 leveled off due to a higher than expected attrition rate and an unprecedented surge in patient volume in the NICU, Labor and Delivery (L&D), and the Emergency Department (ED). During the third quarter of 2007, registry usage as compared to the same period in 2006, declined by 17%,

or only 1,104 hours with an overall decrease in usage of 53% for 2006-07. It is anticipated that the Registry usage will continue to decline in 2007-08 and 2008-09 with additional decreases of 16% (exceeding the target of 14%) and 13% respectively.

3B. To combat staffing shortages, Nursing Services will continue its efforts to market and recruit nurses. ARMC will continue to recruit through advertisements and job fairs. ARMC will continue to have a presence at the local nursing schools and universities during job fairs. In addition, ARMC will continue to host open house to attract and recruit nurses. For retention, nurses at ARMC are given the opportunity to cross train into specialty care services such as Neonatal Intensive Care (NIC), Labor and Delivery (L&D), and Emergency nursing. To date, six nurses from the Medical/Surgical care units have cross-trained and are working in the Emergency Department. In addition, the Neonatal Intensive Care (NIC) and Labor & Delivery (L&D) departments continue to offer courses and training programs to recruit both experienced and new RN graduates.

The areas of overlap between Department of Public Health (DPH) and the Clinical Laboratory are in the testing sections of Microbiology, Infectious Diseases, Molecular Diagnostics, and Immunology. The actual savings of $4,720 was realized from the transitioning of Treponema Pallidum Particle Agglutination (TPPA) and Tuberculosis sensitivities (TB) from ARMC's Clinical Lab to the Public Health Lab. The estimated $10,000 cost savings in 2007-08 is due to additional tests transitioning to the Public Health Lab beginning third quarter of 2007-08. Assuming the acquisition of automation, the Hepatitis panels could be automated, thus saving in labor costs. Hepatitis testing could be maintained by the Clinical Laboratory, reassigning the task to the chemistry department. The consolidation of test platforms through Total Lab Automation (TLA) will afford the lab the ability to eliminate up to four instruments, thus eliminating reagent and supply costs for instrument maintenance and technologist time involved in that maintenance. In addition, as a result of TLA, several send out tests could be brought back into the Clinical lab at lower cost as a result of the larger test menus now available on current instrumentation.

The Department of Pharmacy will continue its practice of ensuring that each patient receives safe and effective medication therapy while controlling the rising costs of pharmaceuticals. This will be accomplished by:
- Continuing to switch to generic pharmaceuticals whenever available
- Using sound formulary management practices
- Continuing to review high cost and high use therapeutic classes on an ongoing basis
- Identifying opportunities for safe and effective therapeutic substitutions and presenting them for approval to the Pharmacy and Therapeutics Committee
- Optimizing our existing antibiotic stewardship program, which will yield lower antimicrobial cost and will decrease bacterial resistance
- Maximizing the efficiency of automated dispensing devices in order to increase turnover of inventory
- Review cases of polypharmacy and, in conjunction with the Medical Staff, streamline therapy in order to enhance compliance and reduce cost

3C. In 2006-07, it was projected that pharmaceutical cost savings would decrease by an additional 40% from the 2005-06 savings of $1.477 million or $590,000. ARMC exceeded that goal with an actual cost savings of an additional $1.18 million. In 2007-08 total pharmaceutical costs are estimated to increase by approximately $316,000 or 1.5% over 2006-07 actual expenditures while still decreasing by 3.5% over 2005-06 actual expenditures. In 2008-09 it is projected that total pharmaceutical costs will increase by 3% or $677,166 over 2005-06 actual expenditures. The annual national increase in pharmaceuticals is approximately 7-10% and ARMC will only have a single increase of 3% for a total of three years. Based on published literature combined with cost containment efforts on the part of the Pharmacy, overall it is the goal to maintain cost increases between 3 to 3.5 % per year which is significantly less than the national average.

3D. Overtime utilization is being evaluated in both service oriented, non-patient care Departments and Patient Care Services with no demonstrable volume fluctuation. Changes in recruitment efforts and hiring practices will demonstrate a visible impact in departments such as Security Services in 2007-08.   High vacancy rates coupled with on-going recruitment and retention issues have dictated the use of scheduled overtime to cover mandatory staffing assignments. Changes in position descriptions, testing requirements and streamlining of the application and hiring processes are on target to fill numerous open positions and stabilize the security workforce thus decreasing the necessity for scheduled shifts at premium rates. The more challenging aspects of Overtime Utilization are the various Patient Care Services within ARMC that continue to face decreasing availability of qualified applicants due to ongoing difficulties in recruitment, inability to compete for limited resources and

retention gaps (trained personnel leaving current employment for increased monetary opportunities). In 2007-08, a 10% decrease in overtime costs is projected for a total savings of approximately $480,000. This trend is expected to continue for 2008-09 with additional savings of $300,000 or $780,000 from 2006-07.

3E.   ARMC is also taking aggressive measures to contain costs in the area of supplies. In 2006-07 total supplies expense was $64 million. A 1% savings or $518,000 is estimated for 2007-08 and a 3% savings or $1,762,000 is projected for 2008-09.

Current fiscal year trend is $1.1 million below budgeted targets from the implementation of the following activities:
- Price model verification.
- Resigning Letters of Commitment.
- Product standardization.

Cost containment activities in progress that will affect 2008-09 supply expenses are:
- Request For Proposal (RFP) for new Group Purchasing Organization (GPO).   Anticipated saving of 1.5%. Award January 2008.
- RFP for medical supply distribution. Anticipated savings of 1%.
- Ongoing product standardization.
- Contract compliance.
- Bulk-buy opportunities for cardiac rhythm management devices.

Risk:
From a macroeconomic viewpoint, consideration must be given to the current economic conditions involving current crude oil prices (≈ $90/barrel), with speculation of it reaching over $110/barrel in the next year, may have a negative effect on our supply costs in 2008-09. Approximately 90% of medical supplies are made from plastic which is a derivative of oil. Raw material costs will escalate and these price increases may be passed on to ARMC in higher supply costs. As well, we can expect freight costs to increase in the form of higher fuel surcharges from the vendors due to the increase of gasoline prices that typically follow the price increase in crude oil.

In anticipation of implementing an Open Heart Program, implants and prosthesis, surgical supplies and packs are anticipated to increase due to added surgical case load and utilization of pacemakers and Automatic Implantable Cardiac Defibrillators (AICDs).

GOAL 4:   ENSURE A QUALITY FOCUS IN THE PROVISION OF PATIENT CARE SERVICES

Objective A: Promote "Evidence Based Nursing Practice" with nurse-sensitive performance and quality indicators.

Objective B: To achieve and maintain a Press Ganey mean average Patient Satisfaction Score of 85%.

Objective C: Obtain Core Measure Compliance in the 90th percentile on all quality indicators by December 2008.

Objective D: Reduce ARMC's rate of Ventilator Associated pneumonia, Catheter Related Blood Stream Infections, Nosocomial Skin Breakdowns and Surgical site Infections below the National Average for Reportable Adverse Outcomes.

MEASUREMENT	2005-06 Actual	2006-07 Actual	2007-08 Target	2007-08 Estimate	2008-09 Target
4A. Achieve Incidence of skin breakdown below National Benchmark (Base in 2006-07 ARMC 10%).	N/A	N/A	4.2% Benchmark 7%	4.2% Benchmark 7%	4.3% Benchmark 7%
4A. Achieve Number of Patient Falls – per 1000 patient days at or below Cal-NOC Standard of 1.79.	N/A	N/A	1.83 1st Qtr	1.79	1.79
4B. Achieve and maintain a mean average score / Likelihood of recommending of 85%.	81.6%	83.7%	83%	83.2%	85%
4C. Achieve and maintain 90th percentile ranking on all Core Measure quality Indicators by December 2008.	N/A	N/A	80%	85%	90+%
4D. Ventilator associated pneumonia (2006-07 actual was 1.6% with a National Benchmark of 4.12%).	N/A	N/A	1%	1%	0%
4D. Central line infection risk (2006-07 actual was 3.3% with a benchmark of 2.1 %).	N/A	N/A	2.2%	1.5%	0%

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4A. Evidence-based practice for nursing is the nursing process that employs conscientious clinical actions driven by best practices that are supported by current research. Evidence-based practice initiatives at ARMC include compliance with nurse-sensitive and core measure performance standards. These quality indicators include progressive wound care practices, implementation of a Rapid Assessment Team, fall prevention, patient education, and use of proven strategies to reduce Ventilator Acquired Pneumonias. For 2007-08, the Nursing department will introduce a culture of Proactive Anticipatory Care by performing hourly rounds within a framework of evidence-based nursing. The framework includes the 4 Ps: Position, Potty, Pain, and Proactive Measures. The Proactive Anticipatory Care model of care delivery has proven to decrease the number of hospital falls, skin breakdown, pain management and patient satisfaction. Additionally, with the implementation of the Proactive Anticipatory Care, ARMC hopes to show a decrease in the number of "sitters" required to monitor at risk patients.

The nursing department will focus on two nurse sensitive performance indicators for the incidence of hospital acquired skin breakdown and falls during hospitalization. These are on-going monitors for all hospitals. ARMC's performance in these two nurse sensitive performance initiatives will be measured against national benchmarks for skin breakdown, comparing ARMC with like hospitals and the Cal-NOC Standard of 1.79 for falls, measured per 1000 patient days.

4B. ARMC's mission in the provision of patient care services is that of quality and customer service. ARMC's current patient satisfaction scores tabulated through Press Ganey, demonstrate a mean average score of 83.2% for 2006-07. The goal of achieving and maintaining a score of 85% in 2007-08 will be addressed throughout the organization as follows:

1. Monthly meetings of the Hospital-wide Multidisciplinary CARE team.
2. Education to all areas of the hospital regarding customer service and the future Press Ganey Scores becoming a public document.
3. Record and recognition to all departments that receive a score of 85 or higher in any category of the survey.
4. Competition amongst departments to reach the highest Press Ganey score on a quarterly basis. Winners to be awarded appropriately.

Results of Press Ganey surveys are available to all Department Managers on a weekly basis through the Press Ganey website. This allows them timely reviews of their areas' survey results. Quarterly reports are reported at the Department Managers' Meeting, Leadership Forum, Quality Management Committee, and Governing Body Meetings.

4C. The Medical Center is required to report our compliance with quality care indicators (Core Measures), to the Centers for Medicaid & Medicare (CMS), on a quarterly basis. These indicators measure compliance with Standards of Care for patients that have Acute Myocardial Infarction, Congestive Heart Failure, Ventilator Acquired Pneumonia, and Post-surgical Procedures. In 2008, Core Measures compliance for hospitals will be available to the general public. Additionally, in 2008-09, CMS will be denying reimbursement to hospitals who do not meet the mean average Core Measure Compliance. Therefore, our goal is to obtain Core Measure Compliance in the 90th percentile for all quality indicators by December 2008. Our compliance is at the 90th percentile with the National average in several indicators. However, the goal encompasses all quality indicators. Hospital-wide education efforts are underway to increase awareness of Core Measure requirements including the future plan of CMS reimbursement based on hospital performance. Monthly reviews of all Core Measures will be conducted with any fall outs requiring peer reviews by the Attending Physicians and Nursing Management. A Multi-disciplinary taskforce has been developed to identify processes and solutions to improve ARMC's compliance with any Core Measure that is not meeting the 90th percentile National comparison.

4D. Through the Performance Improvement Process, ARMC will continue to reduce the rate of Ventilator Acquired Pneumonia, Catheter Related Blood Stream Infections, and Nosocomial Skin Breakdowns. The goal is to be below the National Average of Reportable Adverse Outcomes. Effective January 2008, all Adverse Outcomes are reportable to the Centers for Medicare and Medicaid Services (CMS). Our goal is to be below the national average for adverse outcomes. ARMC monitors these rates on an on-going basis. For 2005-06 the Ventilator Acquired Pneumonia rate was 5.7% and for 2006-07 it was 1.6%, the National benchmark is 4.12. The Central line infection rate for 2005-06 was 4.1% and for 2006-07 it was 3.3% with a National benchmark of 2.1%. The estimated rates for 2007-08 are 1% for Ventilator Acquired Pneumonia and 1.5% for the central infection rate. Projected rates for both monitors are 0% for 2008-09. To facilitate this effort, Hospital–wide education will be conducted on Infection

Control practices; Ongoing Patient surveillance, Monitoring Central Lines, and Ventilator support will be managed by the Infection Control Department. ARMC's Multi-disciplinary Performance Improvement Team on Prevention of Skin Breakdown will continue to perform education and monitoring of proper techniques to prevent skin breakdown. All reports of Adverse Outcomes are reported at the Infection Control Committee, the Quality Management Committee, and the Governing Body Committee on a quarterly basis.

Goal # 5 from the 2007/08 Business Plan is monitored and updated on an on-going basis by the Medical Center – it will be removed from the 2008/09 Business Plan. Key components of Technology upgrades/changes will be added to the Goals and Objectives in each annual business plan – as applicable.

GOAL 5:   MAINTAIN AND IMPROVE THE INFORMATION TECHNOLOGY (IT) INFRASTRUCTURE

Objective A: Meditech Upgrade from 5.5 to 5.6

Objective B: Build, install, and implement the following modules:
   a. Authorization Referral Module (ARM).
   b. Medical Practice Management (MPM/LSS) part 1 – administrative.
   c. Medical Practice Management (MPM/LSS) part 2 – clinical.

Objective C: Install and implement the Home Health Billing Software.

Status
Technology is a vital component to every aspect of ARMC operations, thus making the maintenance and continual improvement of the information technology infrastructure very important. To achieve this goal, it is necessary to evaluate necessary information technology equipment and software required for the following:
a.   Data Repository – a module used to increase the speed and utilization of Meditech data. (This module is currently in production awaiting program changes from Meditech to allow for greater flexibility.)
b.   Data Center Computer Servers replacement due to aging of servers – Meditech servers completed November 06. (All other servers are to be completed by January 2008 due to budget constraints.)
c.   Picture Archiving Communication System (Medical Imaging System) – Previous PACS system was converted to McKesson PACS and went live August 2006. McKesson Cardiology PACS began full implementation in February 2007.)
d.   Home Health Billing Software – This project is in progress and a prospective vendor has been selected. Contract and board item are in process.

ARMC's objective of upgrading to 5.6 has not been completed to-date. The latest available version is 5.54 SR 13 which is due to go live in February 2008. Meditech upgrade from 5.3 to 5.5 was completed in March 2006 and interfaces such as:
a.   Inland Empire Health Plan (IEHP) Interface will provide IEHP patient encounter data in a standard health care claim format (837). This is no longer a valid project because IEHP is unable to support at this time.
b.   CBORD Nutrition Services interface provides dietary orders from Meditech to Nutrition Services. This project is proposed for inclusion in current Capital Budget allocations.
c.   Medical Imaging System (PACS) interface – sends radiology orders and transcribed radiology reports from Meditech to McKesson PACS. This was completed July 2006.
d.   MUSE Cardiology project is intended to send patient registration data and orders to the MUSE cardiac care system. This project is on hold awaiting MUSE database modification.   This is being reviewed for validation of continued use of current out-dated equipment.
e.   MD Staff System interface to Operating Room Scheduling module - This module will transmit MD operating room privilege status updates to Meditech. It is in process and ARMC is working with the vendor to finalize interface specifications.
f.   Imaging project for Personnel System was completed September 2006.
g.   Accucheck interface with Meditech will send blood glucose test results to the Meditech System. This project is in process. ARMC is working with vendor to finalize interface specifications.
h.   Collection interface allows County Collections Department to have access to Meditech Patient Accounting to post payments and adjustments. This project is no longer valid.

The additional Meditech modules including ARM and MPM/LSS for both administration and clerical use have made progress as well. ARM went into production on May 1, 2007, MPM/LSS part 1 for administration went into production November 1, 2007 and MPM/LSS part 2 clinical will go live in November 2007. Additionally, the Quality Management /

Risk Management Module was completed in July 2006 and the Emergency Department Module tracker portion was put into production September 20, 2007.

ARMC continues to assist Public Health Department and Department of Behavioral Health with Meditech implementation. ARMC is working with Public Health daily and to date; Behavioral Health has decided not to use Meditech. Additionally, ARMC is implementing Computerized Physicians Order Entry (CPOE) throughout the hospital and Family Health Centers. Work for the hospital is in process and the live date is unknown. Family Health Centers have started training on new MPM module. Live -November 2007.

ARMC's 2008-09 goals were selected to coincide with the primary mission of the Medical Center and strategic plan for meeting current service demands and future service requirements in a dynamic healthcare environment of changing reimbursement structures and diminishing resources. Having been at capacity shortly after opening its doors, the Medical Center's most pressing issue remains lack of inpatient beds. With due consideration to the significant impact on expansion and progression of the healthcare delivery system, and ARMC's ability to adequately serve an area of growth and development, the Board of Supervisors approved an 84-bed expansion of ARMC's inpatient capacity. ARMC continues to develop a high performance workforce in a climate of national shortage of registered nurses, clinical laboratory scientists, radiologic technologists, respiratory care practitioners, and physical, occupational and speech therapists. Efforts continue to be directed toward immediate, intermediate, and long term remedies. The Medical Center's long-term (2 – 5 years) strategic plan encompasses the following:

1. Increase Bed Capacity – Expansion of 84 beds on sixth floor of ARMC's patient tower. Sixth floor design is complete and includes 30 beds in the north unit, 30 beds in the south unit and 24 in the center unit. The expansion/remodel project will result in 72 private rooms and 12 semi private rooms. Temporary placement for displaced employees will consist of a Modular Building Solution on the Northwest corner of the campus. Nine 4300 square foot modulars will house the Medical Staff and various departments relocated from the hospital proper. Proposed completion date of the sixth floor expansion is estimated to be mid 2009.
2. The sixth floor expansion plan includes the construction of a three story (60,000 square ft.) Medical Office Building (MOB) on the ARMC Campus to house the Medical Staff and Administration displaced by the sixth floor conversion. The MOB will also house selected services and departments not requiring acute care space and expanded outpatient services. Construction is planned simultaneously to the sixth floor expansion project with similar completion dates of mid 2009.
3. Parking has found temporary relief in the recent addition of approximately 138 parking spaces. An additional 140 parking spaces will be provided in the temporary Modular site. ARMC has an approved Capital Improvement Request for the current fiscal year to add approximately 28 additional clinic parking spaces. However, with the 84-bed planned expansion, parking access and availability will require further consideration.
4. Continue in the direction of a "Health Care Agency" concept of operations for San Bernardino County; integrating services where appropriate and co-locating, where feasible, the administrative functions of Public, Behavioral Health, and the Medical Center.

2008-09 REQUESTS FOR ADDITIONAL GENERAL FUND FINANCING (POLICY ITEMS), INCLUDING NEW CAPITAL IMPROVEMENT PROGRAM (CIP) PROJECTS, OR BUSINESS PROCESS IMPROVEMENT (BPI) RESERVE FUNDS

Brief Description of Policy Item, CIP, or BPI reserve funds request	Budgeted Staffing	Appropriation	Dept. Revenue	Local Cost
1. Develop and Implement Full Scope Cardiac Surgery Program	To be determined	2,000,000	2,000,000	-
ARMC's Goal #1 is to increase selected Medical Center volumes. The development and implementation of a Heart program is Objective F under that goal. ARMC currently transports patients requiring cardiac surgery to other area hospitals at an annual cost of approximately $2million. Program implementation will decrease contractual costs and complement services at ARMC for attaining a Level I Trauma designation. Equipment costs are estimated at approximately $2 million for start up of the Cardiac Surgery Program. Program implementation is targeted for the first quarter of 2008/09. Supports Goal No. 1.				
2. Add adjacent 2400 square foot building to the McKee Family Health Center Site – Leased Building		525,000	525,000	-
The McKee Family Health Center (FHC) is one of ARMC's offsite primary care clinics. McKee provides approximately 2,000 visits monthly. It is the newest primary care clinic and has the capability of performing simple X-ray exams (extremities) and performs approximately 100 X-rays per month. The clinic has outgrown its Medical Record space. Currently, they have to purge patient records every eighteen months. The additional space would allow co-location of Behavioral Health, provide medical offices, conference/training room, stations for interns & residents, and a break room for staff, freeing up proximal clinical space in the original clinic proper, offering three additional exam room conversions. Behavioral Health would have 2 exam rooms and their own Medical Records room. The $525,000 includes the estimated tenant improvements and lease amendment payments to the term of the existing McKee lease. At the end of that term, all tenant improvements would be paid and any extensions negotiated with the amendment would include rent only for both spaces. Supports Goal No. 1.				

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MEASUREMENT	2005-06 Actual	2006-07 Actual	2007-08 Target	2007-08 Estimate	2008-09 Target
P1. Proposals for Cardiac Surgery Group are being reviewed. Target implementation date is 1st quarter of 2008-09.					1st quarter 2008-09
P2. Amend and extend McKee's current lease agreement to incorporate the additional space by first quarter of 2008-09.					1st quarter 2008-09

2008-09 PROPOSED FEE ADJUSTMENTS

The department is not requesting any proposed fee adjustments for 2008-09.

If there are questions about this business plan, please contact Colene Haller, Chief Operating Officer at (909) 580-6180.